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F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for investigation of complaint #KS00087113.	F 000		
F 223 SS=L	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents with 3 residents selected for sample. Based on observation, interview and record review, the facility failed to ensure each resident had the right to be free from physical abuse. Resident #1 entered resident #4's room and beat the resident on the face and head, pulled the resident to the floor, and then repeatedly hit the resident's head against the floor. Facility staff witnessed the event and did not physically intervene. After approximately 5 minutes, resident #1 stopped beating resident #4 and left the room. Resident #4 experienced severe injuries that necessitated transfer to a specialty hospital. Resident #4 expired on 6/8/15 from injuries inflicted by resident #1. The facility's failure to develop/implement specific individualized interventions to address resident #1's recent hospitalization for management of physical aggression, facility failure to ensure all staff	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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received training in how to deal with unmanageable, violent residents, and failure to intervene appropriately when a resident physically attacked another resident, placed all facility residents in immediate jeopardy.

Based on observation, interview and record review, the facility failed to take sufficient action to prevent abuse when Resident #2 developed increasingly agitated/aggressive behaviors after he/she refused antipsychotic medications for several weeks, and after staff failed to notify the physician in a timely manner of those refusals. After his/her behaviors escalated, resident #2 initiated two physical altercations (shoving/hitting) with residents within a 48 hour time period which resulted in his/her transfer to a mental health hospital.

Findings included:

- Resident #1's clinical record included diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought with a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).
The 1/14/15 Quarterly MDS (Minimum Data Set) identified resident #1 with no cognitive impairment, no acute onset of mental status change, no hallucinations or delusions, rejection of care 4-6 days within the 7 day observation period, no wandering behaviors, and use of antipsychotic, antianxiety and antidepressant

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medication daily.

The 4/6/15 Annual MDS identified resident #1 with no cognitive impairment, no acute onset mental status change, the presence of hallucinations and delusions, no physical behaviors directed toward others, the presence of other behaviors which did not put the resident or others at significant risk for physical illness or injury 4-6 days during the 7 day observation period, improved behaviors compared to the prior assessment, and use of antipsychotic, antianxiety and antidepressant medication daily.

CAAs (Care Area Assessments) completed on 4/8/15 included:

o Behaviors: "Resident with long standing displayed behaviors of having difficulty focusing on conversations and resident changes subjects often with diagnosis of unspecified schizophrenia. Resident with behaviors of voicing delusional statements, auditory hallucinations and pacing in hallways. Resident's behaviors do not place [him/her] or peers in immediate threat at this time. Facility staff trained to deal with behaviors and de-escalation of behaviors."

o Moods: "Resident with long standing behavior of keeping to self and attending few activities. Schizophrenia and traumatic brain injury."

o Psychotropic drug use;" Resident is on long term psychotropic medication for treatment of schizophrenia. Psychiatrist with monthly visits to facility to evaluate medication regimen."

Resident #1's 4/23/14 care plan included the following:

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o "I take antipsychotic medications due to my mental illness of paranoid schizophrenia and schizoaffective disorder. If I continue to display behavior or my behavior worsens, the staff will contact the psychiatrist."

o "Staff will check on me at least every two hours and document on the clipboard" (4/23/14)

o "I have behaviors of threatening peers/staff, urinating/defecating on floor, eating/taking food to my room, ignoring staff, going from staff to staff until getting my way, bumming cigs and money and drinks. Staff to document behaviors as they are seen. Staff to redirect behaviors as they occur. [Family member] to be notified of increase in behaviors. Psychiatrist to be notified of new/worsening behaviors." (2/18/15)

o "I had a physical altercation with a [male/female] peer on previous night. I will have no further physical altercations with peers over the next 90 days. I will talk with staff if I feel anger/upset at anyone over the next 90 days. Attempt to redirect if noted to be getting upset (pacing more, clenching fists, statements; notify screener for resident to be screened if see increased escalation anger/behaviors. Encourage resident to stay away from [male/female] peer who had resident altercation. Screened to [mental health hospital] due to increased anger/physical with another peer." (5/6/15).

o "I readmitted from [mental health hospital] due to I became upset and had physical aggression with 2 peers and was screened to [mental health hospital] on 5/7/15. I will continue to display no anger/aggression or cause physical harm to my

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peers as this was [mental health hospital's] discharge goal. I will continue this for the next 90 days. Resident continued with previously listed interventions. Res. reminded that if [he/she] had another physical altercation, screener would be contacted." (5/14/15)

The care plan lacked evidence that staff reviewed and revised it with specific interventions upon resident #1's return from the mental health hospital on 5/14/15 to address the recent history of increased physical aggression/physical contact directed at peers.

Progress Notes included the following:

o 5/6/15 at 5:45 p.m.: This entry described an incident that occurred when another resident walked by resident #1 and tapped/hit him/her on the right side of the body. Resident #1 then ran after the other resident, grabbed his/her hair, and pulled the resident to the floor. The facility notified the guardian and physician of the incident.

o 5/7/15 at 12:49 p.m.: This entry described an incident between resident #1 and another resident that occurred when resident #1 yelled a profanity and then attempted to "punch" the other resident. The facility notified the guardian and then contacted a mental health screener to evaluate the resident's recent behavior changes.

o 5/7/15 at 4:25 p.m.: This entry described the completion of a mental health screen by a qualified mental health professional and subsequent transfer to mental health hospital for treatment of increased agitation and increased physical contact with two residents within a 24 hour time period.

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Resident #1 returned from the mental health hospital on 5/14/15. A "Nursing Admission Evaluation" on the resident's return to the facility on 5/14/15 described the resident as alert and oriented, verbally appropriate, pleasant and content. The assessment also noted the resident's history of depression, history of physical aggression, history of being verbally abusive, the presence of hallucinations, and use of antipsychotic, antianxiety, and antidepressant medications.

Discharge notes dated 5/14/15 from the mental health hospital noted resident #1 reported no hallucinations or delusions at the time of discharge and no homicidal or suicidal ideation. Discharge instructions included:

* Utilize free time by doing healthy, meaningful activities

* Participate in therapy to learn and practice healthy coping skills for various issues and effective stress management.

Review of resident #1's care plan after readmission to the facility on 5/14/15 revealed no evidence staff reviewed/revised the care plan with the previously described discharge instructions.

Additional Progress Notes after resident #1's readmission included:

o 5/15/15 at 1:00 a.m.: This entry described resident #1's refusal of vital signs and refusal of an assessment of an infected foot/toe.

o 5/15/15 at 10:17 a.m.: This entry described the

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resident's compliance with taking medications and eating a meal in the dining room with other residents without incident.

o 5/16/15 at 12:51 p.m.: This entry described episodes of urinary incontinence that morning, and described the resident as "walks around in a daze." The note also described how resident #1 "packed out" his/her room that morning and took all of his/her clothing and room items into the hallway and then returned them to his/her room. According to the note, "[He/she] is not responding to staff interaction...".

o 5/17/15 at 1:40 a.m.: This entry described the resident's compliance with taking medications on the evening shift and described him/her as "walking in hall laughing loudly."

Then, on 5/17/15 at 8:45 p.m., a Progress Note included the following: "Call received from nursing on duty at facility that resident (resident #1) attacked [another resident]. Resident in custody of LE [law enforcement] and transported to jail. Contacted screener who will complete screen [mental health screen] in jail."

A later Progress Note in resident #1's clinical record dated 5/19/15 at 2:44 p.m. described the 5/17/15 incident as follows: "Resident was having a routine evening, walking in halls and outside, going to smoke breaks. After resident ate supper, nurse reminded resident to stop at medication cart for supper meds. Resident ignored nurse and walked on to room to lay down. After several minutes of walking around facility, resident came to med cart for HS [hour of sleep/bedtime] meds at 1945 [7:45 p.m.]. 1700 [5:00 p.m.] meds given at this time along with HS meds. At 2015 [8:15

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p.m.] nurse at med cart heard an unusual clanging sound. Upon investigation, observed this resident [resident #1] in [resident #4's] room, standing over [him/her] in bed, hitting [him/her] repeatedly in the face and head.....wouldn't stop, nurse called 911. This resident threw [resident #4] off the bed head first and continued hitting [him/her] and banging [his/her] head against the floor....Another resident intervened and got this resident away."

The facility completed an investigation into the previously described incident which described how resident #1 walked into resident #4's room and began hitting him/her in the face with both hands. According to the facility's investigation, Licensed Nurse D heard an unusual noise and went to investigate the origin. Nurse D found resident #1 standing over resident #4's bed, striking the resident in the head. Nurse D yelled at Resident #1 to stop and then called for assistance of other staff. Resident #1 then pulled resident #4 off the bed, repeatedly struck him/her in the face and head, and then banged the resident's head against the floor. While the altercation between resident #1 and resident #4 took place, Licensed Nurse D called "emergency responders" for assistance. Resident #1 eventually stopped beating resident #4 after another resident intervened and "held" resident #1 from doing more damage to resident #4. Emergency medical staff stabilized resident #4 and sent him/her to an outlying hospital via a helicopter. As of 5/21/15, the date of the facility investigation, resident #4 remained at the hospital in critical condition, and resident #1 remained at a mental health hospital.

Behavior monitoring completed by licensed

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nurses on 5/16/15, the day prior to the incident between resident #1 and #4, noted that resident #1 experienced auditory hallucinations on the day shift.

According to the schedule for 5/17/15, the day of the incident between resident #1 and #4, nursing staff for the afternoon/evening shift consisted of two staff members, Licensed Nurse D and Direct Care Staff E. Staffing schedules for the entire month of May 2015 included assignment of 1 nurse aide and one licensed nurse to the evening shift routinely throughout the month.

During an interview on 6/9/15 at 2:00 p.m., Administrative Nurse C reported resident #4 expired on 6/8/15 from injuries received in the 5/17/15 incident with resident #1.

During an interview on 7/16/15 at 8:40 a.m., Office Staff F reported staff must recertify in CPI (Crisis Prevention Interventions) training each year. Staff F also reported a contracted CPI instructor provided the classes, and conducted them when several people needed the class. According to Staff F, newly hired employees do not take the CPI class prior to starting work at the facility, but are enrolled in the first available class after they are hired.

During an interview on 7/16/15 at 8:50 a.m., Administrative Nurse C reported all staff received CPI training in order to know how to deal with resident behaviors and de-escalation techniques.

According to the CPI (Crisis Prevention Interventions) participant workbook dated 2005 with a reprint date of 2014, "The philosophy of the CPI program is to provide the best care, welfare,

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safety and security for the individuals in your charge, even in violent moments....has been proven effective in potentially violent situations." The CPI workbook included "Preventive Techniques", "Nonviolent Crisis Intervention" and team intervention. Objectives for trainees, included:

1) Training staff with effective techniques in approaching and reducing the tension of an agitated person.

2) Focusing on the alternatives if a person loses control and becomes violent.

3) Instructing staff members in techniques to control their own anxieties during interventions and maintain the best possible professional attitude.

4) Providing nonverbal, paraverbal (the messages that we transmit through the tone, ptich and pacing of our voices), verbal and physical intervention skills to allow the staff to maintain the best possible care and welfare, as well as safety and security, for all involved - even during the most violent moments.

The workbook directed staff to avoid overreaction or under-reaction. "Use verbal intervention skills to intervene with a verbally acting out person. However, when the aggression becomes physical, you must also have in your repertoire of skills safe physical intervention techniques to control the physical acting-out behavior."

During a telephone interview on 7/16/15 at 4:00 p.m., Administrative Staff A reported he/she contacted the facility's CPI trainer and learned the

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trainer did not teach facility staff the methods to physically intervene when a resident is violent as taught in the CPI manual. According to Staff A, the facility decided "3, 4 or 5 years ago" to stop training staff how to intervene physically because there was concern with the "size and strength of the residents." Staff A could not verbalize what policies the facility put into place to handle violent residents when they stopped providing CPI training that covered that area. According to Staff A, staff should call 911 if a resident became violent and should not intervene physically while they awaited response from law enforcement.

During an interview on 6/9/15 at 4:10 p.m., Administrative Nurse B reported a mental health screener determined resident #1 required admission to a mental health hospital in early May 2015 after he/she had two physical altercations with other residents within a 24 hour time period. According to Nurse B, resident #1 behaved normally for him/her upon readmission to the facility and on 5/17/15, the day of the incident, did not exhibit any signs of aggression after readmission until the time of the beating incident with resident #4. Nurse B reported, "There were no warning signs. [He/she] just attacked [resident #4]. Upon review of the clinical record, Nurse B reported the facility completed charting every shift for 72 hours for resident #1 upon readmission on 5/14/15 which is the facility's standard process for all readmissions. Nurse B also reported staff monitored resident #1's whereabouts every 2 hours upon readmission, which is also the process for all facility residents. Nurse B could not verbalize any additional interventions implemented upon resident #1's 5/14/15 readmission to address the recent history of physical aggression toward other residents.

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During an interview on 7/16/15 at 9:46 a.m., Licensed Nurse D confirmed he/she worked the evening shift on 5/17/15, the night of the incident between resident #1 and resident #4. Nurse D reported resident #1 acted normally for him/her through the early hours of the shift. After resident #1 took his/her medications, he/she went to lay down for awhile. A short time later the resident went out to smoke with other residents and a staff member and had no behaviors during that outing. Nurse D saw resident #1 return to his/her room after smoking. A short time later Nurse D heard a strange noise coming from somewhere in the South hallway and went to investigate. Nurse D reported he/she stopped outside of resident #4's room where the noise came from, and observed resident #1 beating resident #4 on the face/head with clenched fists. According to Nurse D, he/she did not enter the room but yelled at resident #1 to stop. In response to that request, resident #1 stopped beating resident #4 "for just a second", stared blankly at Nurse D, and then resumed the beating. Nurse D called out for help from the other staff member working that shift, Direct Care Staff E. As Nurse D turned to go to the Nurses Station to call 911, he/she saw resident #1 throw resident #4 onto the floor and start beating his/her head against the floor. After he/she called 911, Nurse D went back to the scene of the incident where Direct Care Staff E and several residents also stood at the doorway. Nurse D recalled that he/she and Staff E repeatedly told resident #1 to stop, but the resident did not respond to their requests and kept beating resident #4. Nurse D estimated the continual beating lasted "a good 5 minutes" before another resident called out to resident #1 from the doorway and convinced him/her to stop beating resident #4. At that time

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resident #1 left resident #4's room and went back to his/her own room. Nurse D recalled that neither staff members or any residents ever entered resident #4's room during the previously described incident, until after resident #1 returned to his/her room. Nurse D estimated it took law enforcement approximately 10 minutes to get to the facility after he/she placed the 911 call because they had to drive from another town several miles away. Nurse D reported he/she did not physically intervene during the incident because of fear resident #1 would hurt him/her, and that would leave only one staff member to deal with the situation and take care of the residents. Nurse D stated, "All my instincts told me it would make things worse for more people if I did (attempt to intervene physically)." Although the facility's initial investigation into this incident included a statement that another resident physically removed resident #1 from resident #4's room in order to stop the beating, Nurse D reported that no one, neither residents or staff, entered resident #4's room during the entire incident. Licensed Nurse D reported he/she completed CPI training annually for many years, but failed to complete the training when the facility offered it in March 2015. Nurse D confirmed he/she lacked current CPI certification.

As requested, the facility provided a list of current employees (as of 7/14/15) as well as dates of CPI and ANE (abuse, neglect, exploitation) training for all staff. According to the list provided, 8 of 32 current staff members lacked CPI training within the last year, including Licensed Nurse D, the nurse who worked on 5/17/15 when resident #1 beat resident #4. Also according to the list, 14 of 32 current staff lacked ANE training within the past year, including Licensed Nurse D. Direct

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Care Staff E, the other staff member on duty at the time of the incident, completed CPI and ANE training within the past 12 months.

According to the facility's current, undated "Unmanageable Residents" policy, "Crisis Prevention Intervention physical control positions may only be used if a resident becomes physically aggressive. Verbal crisis prevention skills must be used at all other times."

The facility's "Abuse Prevention Program" policy with a revision date of September 2012 included, "The facility administration and employees are committed to protecting resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individual....The abuse prevention program provides policies and procedures that govern...mandated staff training/orientation programs that includes abuse prevention, identification and reporting of abuse...."

The facility failed to ensure each resident had the right to be free from physical abuse when staff failed to develop and implement specific, individualized interventions related to aggression for resident #1 upon his/her readmission to the facility from a mental health hospital where he/she underwent evaluation and treatment for physical aggression. The facility failed to have trained staff availale to address violent altercations between residents. These facility failures placed all residents in immediate jeopardy.

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The facility abated the immediate jeopardy on 7/22/15 at 3:15 p.m. by implementing the following measures:

1) Revised admission screening polices to include special assessment of prospective resident's histories of previous violent behaviors and diagnoses of traumatic brain injuries.

2) Review of all current resident's clinical records in order to identify current residents with histories of violent behaviors and/or aggression, and them development and implementation of individualized care plans/interventions to address those behaviors.

3) Completed CPI training for all but two staff members who were unavailable for training. The two staff members will receive CPI training on 8/1/15.

4) Evaluated staffing levels to ensure that two CPI certified staff remain on duty at all times, around the clock, with plans for additional staff support when resident behaviors/needs require increased staffing levels.

5) Revised the facility policy for how to handle "unmanageable residents."

After abatement of the immediate jeopardy, the deficient practice remained at a scope/severity of "G."

- Resident #2's clinical record included multiple medical diagnoses including schizoaffective disorder (a condition in which a person experiences a combination of symptoms such as hallucinations and delusions, and mood disorder

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symptoms such as mania or depression), pseudobulbular affect (a neurological disorder characterized by involuntary cry or uncontrollable episodes of crying, laughing or other emotional displays), psychosis (any major mental disorder characterized by a gross impairment in reality testing) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The 3/26/15 Annual MDS (Minimum Data Set) identified resident #2 with no cognitive impairment, no acute onset of mental status change, the presence of behavioral symptoms not directed toward others 1 to 3 days during the 7 day observation period, the presence of hallucinations and delusions, behaviors not directed toward others 1-3 days during the 7 day observation period, behaviors did not put resident or others at risk for physical illness/injury.

CAAs (Care Area Assessments) completed after 3/26/15 Annual MDS included the following:

o Behaviors: Resident with long standing displays of inattention, disorganized thinking and staring into space as part of behavior displayed with mental illness of schizoaffective disorder. Resident with behaviors of yelling, laughing and crying loudly when pacing in hallways at times. Resident with long standing refusal to have labs drawn and at times refusing to bathe. Resident's behaviors do not place resident or peers in immediate threat at this time.

The 6/15/15 Admission MDS identified resident #2 with no cognitive impairment, the presence of

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moods, the presence of hallucinations and delusions, the presence of behaviors not directed toward others, behaviors did not put the resident or others at risk for physical illness or injury, and use of antipsychotic and antidepressant medication daily.

CAAs (Care Area Assessments) completed on 6/16/15 included:

o Behaviors: 'Resident with long-standing behaviors displayed of pacing in hallway, talking to self/unseen persons, yelling/crying loudly, refusing medications, hallucinations and voicing delusional statements. Resident's behaviors do not place self or others in immediate threat at this time. Resident with long-standing displays of listed behaviors and have become part of residents usual routine. At times behaviors are purposeful such as when refusing medications or bathing. At times behaviors without any noted reason. Resident with long-standing mental illness and displays behaviors associated with illness. Resident's behaviors unable to be controlled when outside facility as not accepted as "normal" in community. Resident's peers with similar behaviors and this allows resident to not feel embarrassed. Facility staff trained to deal with behaviors and techniques for de-escalation of behaviors. Will continue to care plan for resident's behaviors. Staff to monitor for behaviors, attempt to redirect and document behaviors when they occur. Psychiatrist to be notified of new or worsening behaviors occurring to determine if medication adjustment is warranted. At this time no referral indicated, however IDT [interdisciplinary team] will continue to monitor and will consult with healthcare professional as needed.'

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The 5/29/13 care plan for resident #2 included:

o "Inappropriate behavior related to schizoaffective disorder and depressive disorder....document behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to physical aggression directed toward other residents.

MARs (Medication Administration Records) directed staff to provide multiple medications to resident #2, including:

o Invega, an antipsychotic medication, 6 mg (milligrams) 2 tablets daily for unspecified psychosis (5/5/15 order)

According to the March 2015 MAR, resident #2 refused the Invega 1 time during the month.

According to the April 2015 MAR, resident #2 refused the Invega 4 times during the month.

According to the May 2015 MAR, resident #2 refused the medication 4 times in the first 4 days of the month.

o Mirtazapine, an antidepressant medication, 15 mg daily for depressive disorder

According to the March 2015 MAR, resident #2 refused the medication 1 time during the month.

According to the April 2015 MAR, resident #2

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refused the medication 17 times during the month.

According to the May 2015 MAR, resident #2 refused the medication 3 times in the first 4 days of the month.

o Simvastatin, a medication used to lower blood cholesterol levels, 20 mg. daily for hyperlipidemia (elevated blood cholesterol),

According to the March 2015 MAR, resident #2 refused the medication 1 time during the month.

According to the April 2015 MAR, resident #2 refused the medication 14 times during the month.

According to the May 2015 MAR, resident #2 refused the medication 3 times in the first 4 days of the month.

o Benztropine Mesylate 1 mg, a medication used to treat involuntary movements due to the side effects of certain psychiatric drugs, twice daily for pseudobulbar affect

According to the March 2015 MAR, resident #2 refused the medication 12 times during the month.

According to the April 2015 MAR, resident #2 refused the medication 34 times during the month.

According to the May 2015 MAR, resident #2 refused the medication 6 times in the first 4 days of the month.

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o Levothroid, a medication used to treat a thyroid disorder, 25 mcg (micrograms) daily for hypothyroidism (an underactive thyroid gland)

According to the April 2015 MAR, resident #2 refused the medication 3 times during the month.

According to the May 2015 MAR, resident #2 refused the medication 2 times in the first 4 days of the month.

Review of resident #2's clinical record (progress notes, physician's orders, faxes to the physician) revealed no evidence staff notified the physician of the resident's increasing refusals of medications, including refusals of medications intended to manage the symptoms of psychosis.

Progress notes dated from 4/1/15 to 5/7/15 included frequent documentation by licensed nurses related to resident #2's refusal of medications and increasing behaviors, including: refusals of medications on April 5, 8, 18, 21, 22, 23, 24, 25, 27, 28, 29 and 30, 2015. Resident #2 also refused medications May 1, 2, 3 and 4, 2015.

According to the progress notes, resident #2 exhibited behaviors as follows:

o 4/7/15: The resident packed clothing and placed the items in a trash bin

o 4/18/15: The resident paced and yelled on the second shift and talked loudly with an agitated voice to him/herself on the 3rd shift.

o 4/24/15 at 11:28 a.m. and 3:54 p.m.: The resident refused medications and reported "There

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are snakes in them."

o 4/26/15: The resident paced the hallways and laughed.

o 4/27/15: Staff noted resident #2 sat in his/her bedroom crying.

o 4/28/15: Staff noted resident #2 had periods of crying loudly and then had occasional laughing. The resident also refused medications because "There's snakes in them."

o 4/29/15: Resident #2 paced the hallways and made "random statements."

o 4/30/15: Staff found resident #2 laying naked on his/her bed with the door open to the main corridor. Later, staff noted the resident paced the halls and laughed.

o 5/1/15: Resident #2 refused medications because they had snakes in them.

o 5/2/15: Resident #2 paced the hallways and made loud, "quick" statements that staff could not understand.

o 5/3/15: Staff noted resident #2 paced and "stood and stared" and again refused medications due to snakes in them.

o 5/4/15: Resident #2 paced the hallways while crying and cursing. At other times the resident paced and laughed.

o 5/4/15 at 9:31 p.m.: At approximately 1955 [7:55 p.m.] this resident violently shoved/pushed [another resident] to "get out of my [expletive]

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way". [Other resident] went approximately 12-15 feet away. Continued yelling for [him/her]to get out of her way .....Writer notified RN (registered nurse) on duty. [Parent] of resident notified and in agreement for placement in another facility for med adjustments. Contracted screener who then instructed this nurse to fax information on resident to [acute psychiatric unit]....no bed available....contacted [another acute psychiatric facility] and waiting on return call.

The clinical record lacked evidence of increased supervision/monitoring of resident #2 after he/she demonstrated physical aggression against another resident as previously described.

Additional progress notes included:

o 5/5/15 at 10:04 a.m.: Resident #2 paced and was tearful.

o 5.7.15 at 12:16 a.m.: This entry described an incident which happened on 5/6/15 at 5:45 p.m. when resident #2 approached another resident and struck that resident without provocation.

According to the Progress Notes dated 5/7/15 at 4:55 p.m., a mental health screener evaluated resident #2 and determined he/she required hospitalization at a mental health hospital.

The clinical record included no evidence the facility notified resident #2's physician of his/her refusal of medications with increasing frequency beginning in April 2015 and continuing throughout the month of April and into early May. The clinical record also included no evidence the facility notified the physician of increased behaviors (crying, cursing, pacing, seeing snakes, paranoia)

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during that same timeperiod. The clinical record included no evidence the facility implemented appropriate interventions to address resident #2's behaviors until the resident physically assaulted/abused two residents.

During observations on 6/9/15 at 2:25 p.m. and 6/10/15 at 8:00 a.m., resident #2 continuously paced the hallways. The resident did not initiate conversation with others during the observations and did not exhibit signs of aggression/violence.

During an interview on 7/16/15 at 9:00 a.m., Administrative Staff A reported resident #2's clinical record lacked evidence of physician notification of his/her increasingly frequent refusal of medications during the months of April and early May, 2015. Staff A also confirmed the clinical record lacked evidence that staff reported an increase in resident behaviors to the physician during that same time period. Administrative Staff A confirmed resident #2 became physical with two residents in early May 2015, and then staff contacted a mental health screener and transferred the resident to mental health hospital. Staff A presented a document dated 7/15/15 from resident #2's psychiatrist which said he/she knew resident #2 refused medications. That document lacked any details of when staff informed the psychiatrist, the frequency of those notifications etc.

According to the facility's "Preventing Resident Abuse" policy with a revision date of September 2012, "The staff will continually monitor the facility's policies, procedures, training programs, systems etc [etcetera] to assist in preventing resident abuse.....Assessing, care planning, and monitoring resident with needs and behaviors that

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F 223	Continued From page 23 may lead to conflict or neglect; Assessing residents with signs and symptoms of behavior problems and developing and implementing fare plans to address behavioral issues..." The facility failed to take sufficient action and provide increased monitoring and supervision to prevent abuse when Resident #2 developed increasingly agitated/aggressive behaviors after he/she refused multiple medications, including antipsychotic medications, for several weeks, and after staff failed to notify the physician in a timely manner of those refusals. After his/her behaviors escalated, resident #2 initiated two physical altercations (shoving/hitting) with residents within a 48 hour time period which resulted in his/her transfer to a mental health hospital.	F 223		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 46 residents, with 3 residents selected for sample. Based on observation, interview and record review, the facility failed to review/revise the care plans for 2 of 3 residents upon their return from the hospital to include specific and individualized interventions related to the aggression/violence that necessitated the residents' hospitalizations and/or to include hospital discharge instructions. (Residents #1 and #2)

Findings included:

- Resident #1's clinical record included diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought with a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The 1/14/15 Quarterly MDS (Minimum Data Set) identified resident #1 with no cognitive impairment, no acute onset of mental status change, no hallucinations or delusions, rejection of care 4-6 days within the 7 day observation period, no wandering behaviors, and use of antipsychotic, antianxiety and antidepressant medication daily.

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The 4/6/15 Annual MDS identified resident #1 with no cognitive impairment, no acute onset mental status change, the presence of hallucinations and delusions, no physical behaviors directed toward others, the presence of other behaviors which did not put the resident or others at significant risk for physical illness or injury 4-6 days during the 7 day observation period, improved behaviors compared to the prior assessment, and use of antipsychotic, antianxiety and antidepressant medication daily.

CAAs (Care Area Assessments) completed on 4/8/15 included:

o Behaviors: "Resident with long standing displayed behaviors of having difficulty focusing on conversations and resident changes subjects often with diagnosis of unspecified schizophrenia. Resident with behaviors of voicing delusional statements, auditory hallucinations and pacing in hallways. Resident's behaviors do not place [him/her] or peers in immediate threat at this time. Facility staff trained to deal with behaviors and de-escalation of behaviors. "

o Moods: "Resident with long standing behavior of keeping to self and attending few activities. Schizophrenia and traumatic brain injury."

o Psychotropic drug use; Resident is on long term psychotropic medication for treatment of schizophrenia. Psychiatrist with monthly visits to facility to evaluate medication regimen.

Resident #1's 4/23/14 care plan included the following:

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o "I take antipsychotic medications due to my mental illness of paranoid schizophrenia and schizoaffective disorder. If I continue to display behavior or my behavior worsens, the staff will contact the psychiatrist."

o "Staff will check on me at least every two hours and document on the clipboard" (4/23/14)

o "I have behaviors of threatening peers/staff, urinating/defecating on floor, eating/taking food to my room, ignoring staff, going from staff to staff until getting my way, bumming cigs and money and drinks. Staff to document behaviors as they are seen. Staff to redirect behaviors as they occur. Father to be notified of increase in behaviors. Psychiatrist to be notified of new/worsening behaviors" (2/18/15)

o "I had a physical altercation with a [male/female] peer on previous night. I will have no further physical altercations with peers over the next 90 days. I will talk with staff if I feel anger/upset at anyone over the next 90 days. Attempt to redirect if noted to be getting upset (pacing more, clenching fists, statements; notify screener for resident to be screened if see increased escalation anger/behaviors. Encourage resident to stay away from [male/female] peer who had resident altercation. Screened to [mental health hospital] due to increased anger/physical with another peer" (5/6/15).

o "I readmitted from [mental health hospital] due to I became upset and had physical aggression with 2 peers and was screened to [mental health hospital] on 5/7/15. I will continue to display no anger/aggression or cause physical harm to my peers as this was [mental health hospital's]

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discharge goal. I will continue this for the next 90 days. Resident continued with previously listed interventions. Res. reminded that if [he/she] had another physical altercation, screener would be contacted" (5/14/15)

The care plan lacked evidence of newly developed individualized, specific interventions upon resident #1's return from the mental health hospital on 5/14/15 to address the recent history of physical aggression/physical contact directed at peers.

Progress Notes included the following:

o 5/6/15 at 5:45 p.m.: This entry described an incident that occurred when another resident walked by resident #1 and tapped/hit him/her on the right side of the body. Resident #1 then ran after the other resident, grabbed his/her hair, and pulled the resident to the floor. The facility notified the guardian and physician of the incident.

o 5/7/15 at 12:49 p.m.: This entry described an incident between resident #1 and another resident that occurred when resident #1 yelled a profanity and then attempted to "punch" the other resident. The facility notified the guardian and then contacted a mental health screener to evaluate the resident's recent behavior changes.

o 5/7/15 at 4:25 p.m.: This entry described the completion of a mental health screen by a qualified mental health professional and subsequent transfer to mental health hospital for treatment of increased agitation and increased physical contact with two residents within a 24 hour time period.

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Resident #1 returned from the mental health hospital on 5/14/15. A "Nursing Admission Evaluation" on the resident's return to the facility on 5/14/15 described the resident as alert and oriented, verbally appropriate, pleasant and content. The assessment also noted the resident's history of depression, history of physical aggression, history of being verbally abusive, the presence of hallucinations, and use of antipsychotic, antianxiety, and antidepressant medications.

Discharge notes dated 5/14/15 from the mental health hospital noted resident #1 reported no hallucinations or delusions at the time of discharge and no homicidal or suicidal ideation. Discharge instructions included:

* Utilize free time by doing healthy, meaningful activities

* Participate in therapy to learn and practice healthy coping skills for various issues and effective stress management.

Review of resident #1's care plan after readmission to the facility on 5/14/15 revealed no evidence staff reviewed/revised the care plan with the previously described discharge instructions.

Additional Progress Notes after resident #1's readmission included:

o 5/17/15 at 8:45 p.m.: "Call received from nursing on duty at facility that resident (resident #1) attacked [another resident]. Resident in custody of LE [law enforcement] and transported to jail. Contacted screener who will complete screen [mental health screen] in jail."

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A later Progress Note in resident #1's clinical record dated 5/19/15 at 2:44 p.m. described the 5/17/15 incident as follows: "Resident was having a routine evening, walking in halls and outside, going to smoke breaks. After resident ate supper, nurse reminded resident to stop at medication cart for supper meds. Resident ignored nurse and walked on to room to lay down. After several minutes of walking around facility, resident came to med cart for HS [hour of sleep/bedtime] meds at 1945 [7:45 p.m.]. 1700 [5:00 p.m.] meds given at this time along with HS meds. At 2015 [8:15 p.m.] nurse at med cart heard an unusual clanging sound. Upon investigation, observed this resident [resident #1] in [another resident's] room, standing over [him/her] in bed, hitting [him/her] repeatedly in the face and head.....wouldn't stop, nurse called 911. This resident threw [other resident] off the bed head first and continued hitting [him/her] and banging [his/her] head against the floor....Another resident intervened and got this resident away."

During an interview on 6/9/15 at 4:10 p.m., Administrative Nurse B reported a mental health screener determined resident #1 required admission to a mental health hospital in early May 2015 after he/she had two physical altercations with other residents within a 24 hour time period. According to Nurse B, resident #1 behaved normally for him/her upon readmission to the facility and on 5/17/15, the day of the incident, did not exhibit any signs of aggression after readmission until the time of the beating incident with resident #4. Nurse B reported, "There were no warning signs. [He/she] just attacked [resident #4]. Upon review of the clinical record, Nurse B reported the facility completed charting every shift

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for 72 hours for resident #1 upon readmission on 5/14/15 which is the facility's standard process for all readmissions. Nurse B also reported staff monitored resident #1's whereabouts every 2 hours upon readmission, which is also the process for all facility residents. Nurse B could not verbalize any additional interventions developed/implemented upon resident #1's 5/14/15 readmission to address the recent history of physical aggression toward other residents.

The facility failed to review/revise resident #1's care plan at the time of readmission to the facility on 5/14/15 to include appropriate measurable goals/specific, individualized interventions related to recent episodes of aggression against other residents that necessitated hospitalization in a mental health hospital. The facility also failed to review/revise resident #1's care plan upon readmission to include discharge instructions from the mental health hospital.

- Resident #2's clinical record included multiple medical diagnoses including schizoaffective disorder (a condition in which a person experiences a combination of symptoms such as hallucinations and delusions, and mood disorder symptoms such as mania or depression), pseudobulbular affect (a neurological disorder characterized by involuntary cry or uncontrollable episodes of crying, laughing or other emotional displays), psychosis (any major mental disorder characterized by a gross impairment in reality testing) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

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The 3/26/15 Annual MDS (Minimum Data Set) identified resident #2 with no cognitive impairment, no acute onset of mental status change, the presence of behavioral symptoms not directed toward others 1 to 3 days during the 7 day observation period, the presence of hallucinations and delusions, behaviors not directed toward others 1-3 days during the 7 day observation period, behaviors did not put resident or others at risk for physical illness/injury.

CAAs (Care Area Assessments) completed after 3/26/15 Annual MDS included the following:

o Behaviors: "Resident with long standing displays of inattention, disorganized thinking and staring into space as part of behavior displayed with mental illness of schizoaffective disorder. Resident with behaviors of yelling, laughing and crying loudly when pacing in hallways at times. Resident with long standing refusal to have labs drawn and at times refusing to bathe. Resident's behaviors do not place resident or peers in immediate threat at this time."

The 6/15/15 Admission MDS identified resident #2 with no cognitive impairment, the presence of moods, the presence of hallucinations and delusions, the presence of behaviors not directed toward others, behaviors did not put the resident or others at risk for physical illness or injury, and use of antipsychotic and antidepressant medication daily.

CAAs (Care Area Assessments) completed on 6/16/15 included:

o Behaviors: 'Resident with long-standing

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behaviors displayed of pacing in hallway, talking to self/unseen persons, yelling/crying loudly, refusing medications, hallucinations and voicing delusional statements. Resident's behaviors do not place self or others in immediate threat at this time. Resident with long-standing displays of listed behaviors and have become part of residents usual routine. At times behaviors are purposeful such as when refusing medications or bathing. At times behaviors without any noted reason. Resident with long-standing mental illness and displays behaviors associated with illness. Resident's behaviors unable to be controlled when outside facility as not accepted as "normal" in community. Resident's peers with similar behaviors and this allows resident to not feel embarrassed. Facility staff trained to deal with behaviors and techniques for de-escalation of behaviors. Will continue to care plan for resident's behaviors. Staff to monitor for behaviors, attempt to redirect and document behaviors when they occur. Psychiatrist to be notified of new or worsening behaviors occurring to determine if medication adjustment is warranted. At this time no referral indicated, however IDT [interdisciplinary team] will continue to monitor and will consult with healthcare professional as needed.'

The 5/29/13 care plan for resident #2 included:

o "Inappropriate behavior related to schizoaffective disorder and depressive disorder....document behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn. The care plan lacked specific

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interventions related to physical aggression directed toward other residents."

An interim care plan upon resident #2's return from the mental health hospital dated 6/2/15 included:

o 3 day charting due to readmission

o Vital signs every shift

o Behaviors and medication compliance

o Physician to be notified of any adverse or physical aggressive behavior due to history. If physical aggression occurs, place resident on 1:1 immediately, notify psychiatrist, notify law enforcement.

The care plan developed upon resident #2's readmission lacked measurable goals and individualized, specific interventions related to increased monitoring of the resident due to the recent history of aggression, and interventions to prevent additional aggression before it occurred. The revised care plan included only interventions to address aggression once it occurred and lacked preventative interventions.

During observations on 6/9/15 at 2:25 p.m. and 6/10/15 at 8:00 a.m., resident #2 continuously paced the hallways. The resident did not initiate conversation with others during the observations and did not exhibit signs of aggression/violence.

During an interview on 7/16/15 at 10:00 a.m., Administrative Staff C confirmed the care plan reviewed/revised after resident #2's readmission on 6/2/15 lacked other interventions related to the

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F 280	Continued From page 34 resident's recent history of aggression directed toward other residents. The facility failed to review/revise resident #2's care plan at the time of readmission to the facility on 6/2/15 to include appropriate measurable goals/specific, individualized interventions related to recent episodes of aggression against other residents that necessitated hospitalization in a mental health hospital.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents, with 3 residents selected for sample. Based on interview and record review, the facility failed to provide 2 of 3 residents with adequate assessment, supervision and interventions to prevent accidents/hazards. Resident #1 and #2 had two incidents each of aggression/violence against other residents which necessitated their hospitalization at hospitals which treated residents with mental illness. Upon both resident's discharges from the hospital and return to the facility, the facility failed to develop and implement appropriate individualized, specific interventions related to recent	F 323		

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aggression/violence directed at other residents, including increased supervision in an attempt to protect all residents. Resident #1 attacked resident #4 within three days of his/her readmission. Resident #4 experienced significant physical injury in the attack and later expired from those injuries. This deficient practice placed resident #4 in immediate jeopardy.

Findings included:

- Resident #1's clinical record included diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought with a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The 1/14/15 Quarterly MDS (Minimum Data Set) identified resident #1 with no cognitive impairment, no acute onset of mental status change, no hallucinations or delusions, rejection of care 4-6 days within the 7 day observation period, no wandering behaviors, and use of antipsychotic, antianxiety and antidepressant medication daily.

The 4/6/15 Annual MDS identified resident #1 with no cognitive impairment, no acute onset mental status change, the presence of hallucinations and delusions, no physical behaviors directed toward others, the presence of other behaviors which did not put the resident of others at significant risk for physical illness or

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injury 4-6 days during the 7 day observation period, improved behaviors compared to the prior assessment, and use of antipsychotic, antianxiety and antidepressant medication daily.

CAAs (Care Area Assessments) completed on 4/8/15 included:

o Behaviors: "Resident with long standing displayed behaviors of having difficulty focusing on conversations and resident changes subjects often with diagnosis of unspecified schizophrenia. Resident with behaviors of voicing delusional statements, auditory hallucinations and pacing in hallways. Resident's behaviors do not place [him/her] or peers in immediate threat at this time. Facility staff trained to deal with behaviors and de-escalation of behaviors."

o Moods: "Resident with long standing behavior of keeping to self and attending few activities. Schizophrenia and traumatic brain injury."

o Psychotropic drug use: "Resident is on long term psychotropic medication for treatment of schizophrenia. Psychiatrist with monthly visits to facility to evaluate medication regimen."

Resident #1's 4/23/14 care plan included the following:

o "I take antipsychotic medications due to my mental illness of paranoid schizophrenia and schizoaffective disorder. If I continue to display behavior or my behavior worsens, the staff will contact the psychiatrist."

o "Staff will check on me at least every two hours and document on the clipboard" (4/23/14)

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o "I have behaviors of threatening peers/staff, urinating/defecating on floor, eating/taking food to my room, ignoring staff, going from staff to staff until getting my way, bumming cigs and money and drinks. Staff to document behaviors as they are seen. Staff to redirect behaviors as they occur. Father to be notified of increase in behaviors. Psychiatrist to be notified of new/worsening behaviors." (2/18/15)

o "I had a physical altercation with a [male/female] peer on previous night. I will have no further physical altercations with peers over the next 90 days. I will talk with staff if I feel anger/upset at anyone over the next 90 days. Attempt to redirect if noted to be getting upset (pacing more, clenching fists, statements; notify screener for resident to be screened if see increased escalation anger/behaviors. Encourage resident to stay away from female peer who had resident altercation. Screened to [mental health hospital] due to increased anger/physical with another peer" (5/6/15).

o "I readmitted from [mental health hospital] due to I became upset and had physical aggression with 2 peers and was screened to [mental health hospital] on 5/7/15. I will continue to display no anger/aggression or cause physical harm to my peers as this was [mental health hospital's] discharge goal. I will continue this for the next 90 days. Resident continued with previously listed interventions. Res. reminded that if [he/she] had another physical altercation, screener would be contacted" (5/14/15)

Progress Notes included the following:

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o 5/6/15 at 5:45 p.m.: This entry described an incident that occurred when another resident walked by resident #1 and tapped/hit him/her on the right side of the body. Resident #1 then ran after the other resident, grabbed his/her hair, and pulled the resident to the floor.

o 5/7/15 at 12:49 p.m.: This entry described an incident between resident #1 and another resident that occurred when resident #1 yelled a profanity and then attempted to "punch" the other resident.

o 5/7/15 at 4:25 p.m.: This entry described the completion of a mental health screen by a qualified mental health professional and subsequent transfer to mental health hospital for treatment of increased agitation and increased physical contact with two residents within a 24 hour time period.

Resident #1 returned from the mental health hospital on 5/14/15. A "Nursing Admission Evaluation" on the resident's return to the facility on 5/14/15 described the resident as alert and oriented, verbally appropriate, pleasant and content. The assessment also noted the resident's history of depression, history of physical aggression, history of being verbally abusive, the presence of hallucinations, and use of antipsychotic, antianxiety, and antidepressant medications.

Discharge notes dated 5/14/15 from the mental health hospital noted resident #1 reported no hallucinations or delusions at the time of discharge and no homicidal or suicidal ideation.

Review of resident #1's care plan after

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readmission to the facility on 5/14/15 revealed no evidence staff reviewed/revised the care plan to include increased supervision due to the recent history of aggression/violence against other residents.

Additional Progress Notes after resident #1's readmission included:

o 5/17/15 at 8:45 p.m.: "Call received from nursing on duty at facility that resident (resident #1) attacked [another resident]. Resident in custody of LE [law enforcement] and transported to jail. Contacted screener who will complete screen [mental health screen] in jail."

A later Progress Note in resident #1's clinical record dated 5/19/15 at 2:44 p.m. described the 5/17/15 incident that involved #1 as follows: "Resident was having a routine evening, walking in halls and outside, going to smoke breaks. After resident ate supper, nurse reminded resident to stop at medication cart for supper meds. Resident ignored nurse and walked on to room to lay down. After several minutes of walking around facility, resident came to med cart for HS [hour of sleep/bedtime] meds at 1945 [7:45 p.m.]. 1700 [5:00 p.m.] meds given at this time along with HS meds. At 2015 [8:15 p.m.] nurse at med cart heard an unusual clanging sound. Upon investigation, observed this resident [resident #1] in [another resident's] room, standing over [him/her] in bed, hitting [him/her] repeatedly in the face and head.....wouldn't stop, nurse called 911. This resident threw [other resident] off the bed head first and continued hitting [him/her] and banging [his/her] head against the floor....Another resident intervened and got this resident away."

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The facility completed an investigation into the previously described incident which described how resident #1 walked into resident #4's room and began hitting him/her in the face with both hands. According to the facility's investigation, Licensed Nurse D heard an unusual noise and went to investigate the origin. Nurse D found resident #1 standing over resident #4's bed, striking the resident in the head. Nurse D yelled at Resident #1 to stop and then called for assistance of other staff. Resident #1 then pulled resident #4 off the bed, repeatedly struck him/her in the face and head, and then banged the resident's head against the floor. While the altercation between resident #1 and resident #4 took place, Licensed Nurse D called "emergency responders" for assistance. Resident #1 eventually stopped beating resident #4 after another resident intervened and "held" resident #1 from doing more damage to resident #4. Emergency medical staff stabilized resident #4 and sent him/her to an outlying hospital via helicopter. As of 5/21/15, the date of the facility investigation, resident #4 remained at the hospital in critical condition, and resident #1 remained at a mental health hospital.

Behavior monitoring completed by licensed nurses on 5/16/15, the day prior to the incident between resident #1 and #4, noted the resident resident #1 had auditory hallucinations on the day shift.

The clinical record lacked evidence of additional supervision of resident #1 upon his/her return from the mental health hospital on 5/14/15 as related to the recent history of aggression/violence against other residents and hospitalization for treatment of those outbursts.

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The facility provided a document which listed all facility residents and on which staff initialed the box under each resident's name every two hours. According to Administrative Staff B, staff who initialed the boxes were required to actually see the residents when they placed their initials on that form. Although requested, the facility could not provide any other documentation that staff monitored/supervised resident #1 more closely after his/her readmission to the facility on 5/14/15.

During an interview on 6/9/15 at 2:00 p.m., Administrative Nurse C reported resident #4 expired on 6/8/15 from injuries received in the 5/17/15 incident with resident #1.

During an interview on 6/9/15 at 4:10 p.m., Administrative Nurse B reported a mental health screener determined resident #1 required admission to a mental health hospital in early May 2015 after he/she had two physical altercations with other residents within a 24 hour time period. According to Nurse B, resident #1 behaved normally for him/her upon readmission to the facility and on 5/17/15, the day of the incident, did not exhibit any signs of aggression after readmission until the time of the beating incident with resident #4. Nurse B reported, "There were no warning signs. [He/she] just attacked [resident #4]. Upon review of the clinical record, Nurse B reported the facility completed charting every shift for 72 hours for resident #1 upon readmission on 5/14/15 which is the facility's standard process for all readmissions. Nurse B also reported staff monitored resident #1's whereabouts every 2 hours upon readmission, which is also the process for all facility residents. Nurse B could not verbalize any additional interventions implemented upon resident #1's 5/14/15

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readmission to address the recent history of physical aggression toward other residents and verified increased supervision of the resident.

The facility's "Abuse Prevention Program" policy with a revision date of September 2012 included, "The facility administration and employees are committed to protecting resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individuals"

This deficient practice placed resident #4 in immediate jeopardy when the facility failed to prevent resident to resident altercations. Resident #1 had two incidents of aggression/violence against other residents which necessitated his/her hospitalization at a mental health hospital. Upon resident #1's readmission to the facility on 5/14/15, the facility failed to develop and implement appropriate individualized, specific interventions related to recent aggression/violence directed at other residents, including increased supervision in an attempt to protect all residents. Resident #1 attacked resident #4 within three days of his/her readmission. Resident #4 experienced significant physical injury in the attack and later expired from those injuries.

The facility abated the immediate jeopardy on 7/22/15 at 3:15 p.m. by implementing the following measures:

1) Revised admission screening polices to include special assessment of prospective

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resident's histories of previous violent behaviors and diagnoses of traumatic brain injuries.

2) Review of all current resident's clinical records in order to identify current residents with histories of violent behaviors and/or aggression, and them development and implementation of individualized care plans/interventions to address those behaviors.

3) Completed CPI training for all but two staff members who were unavailable for training. The two staff members will receive CPI training on 8/1/15.

4) Evaluated staffing levels to ensure that two CPI certified staff remain on duty at all times, around the clock, with plans for additional staff support when resident behaviors/needs require increased staffing levels.

5) Revised the facility policy for how to handle "unmanageable residents."

After abatement of the immediate jeopardy, the deficient practice remained at a scope/severity of "G."

- Resident #2's clinical record included multiple medical diagnoses including schizoaffective disorder (a condition in which a person experiences a combination of symptoms such as hallucinations and delusions, and mood disorder symptoms such as mania or depression), pseudobulbular affect (a neurological disorder characterized by involuntary cry or uncontrollable episodes of crying, laughing or other emotional displays), psychosis (any major mental disorder characterized by a gross impairment in reality

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testing) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The 3/26/15 Annual MDS (Minimum Data Set) identified resident #2 with no cognitive impairment, no acute onset of mental status change, the presence of behavioral symptoms not directed toward others 1 to 3 days during the 7 day observation period, the presence of hallucinations and delusions, behaviors not directed toward others 1-3 days during the 7 day observation period, behaviors did not put resident or others at risk for physical illness/injury.

CAAs (Care Area Assessments) completed after 3/26/15 Annual MDS included the following:

o Behaviors: "Resident with long standing displays of inattention, disorganized thinking and staring into space as part of behavior displayed with mental illness of schizoaffective disorder. Resident with behaviors of yelling, laughing and crying loudly when pacing in hallways at times. Resident with long standing refusal to have labs drawn and at times refusing to bathe. Resident's behaviors do not place resident or peers in immediate threat at this time.:"

The 6/15/15 Admission MDS identified resident #2 with no cognitive impairment, the presence of moods, the presence of hallucinations and delusions, the presence of behaviors not directed toward others, behaviors did not put the resident or others at risk for physical illness or injury, and use of antipsychotic and antidepressant medication daily.

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CAAs (Care Area Assessments) completed on 6/16/15 included:

o Behaviors: "Resident with long-standing behaviors displayed of pacing in hallway, talking to self/unseen persons, yelling/crying loudly, refusing medications, hallucinations and voicing delusional statements. Resident's behaviors do not place self or others in immediate threat at this time. Resident with long-standing displays of listed behaviors and have become part of residents usual routine. At times behaviors are purposeful such as when refusing medications or bathing. At times behaviors without any noted reason. Resident with long-standing mental illness and displays behaviors associated with illness. Resident's behaviors unable to be controlled when outside facility as not accepted as "normal" in community. Resident's peers with similar behaviors and this allows resident to not feel embarrassed. Facility staff trained to deal with behaviors and techniques for de-escalation of behaviors. Will continue to care plan for resident's behaviors. Staff to monitor for behaviors, attempt to redirect and document behaviors when they occur. Psychiatrist to be notified of new or worsening behaviors occurring to determine if medication adjustment is warranted. At this time no referral indicated, however IDT [interdisciplinary team] will continue to monitor and will consult with healthcare professional as needed."

The 5/29/13 care plan for resident #2 included:

o Inappropriate behavior related to schizoaffective disorder and depressive disorder....document behaviors in soon as occurs, remind resident of

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need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to physical aggression directed toward other residents.

Progress Notes for resident #2 included:

o 5/4/15 at 9:31 p.m.: "At approximately 1955 [7:55 p.m.] this resident violently shoved/pushed [another resident] to "get out of my [expletive] way". [Other resident] went approximately 12-15 feet away. Continued yelling for [him/her]to get out of her way .....Writer notified RN (registered nurse) on duty. [Parent] of resident notified and in agreement for placement in another facility for med adjustments. Contracted screener who then instructed this nurse to fax information on resident to [acute psychiatric unit]....no bed available....contacted [another acute psychiatric facility] and waiting on return call."

o 5/5/15 at 1321: Contact [psychiatrist]...meds changed....agrees to evaluation for inpatient stay at another facility to adjust medications.

o 5.7.15 at 12:16 a.m.: described incident which happened on 5/6/15 at 1745 where resident #2 approached another resident and struck that resident without provocation.

A subsequent progress note documented resident #2's transfer to a mental health hospital on 5/7/15 for evaluation and treatment of aggressive behaviors.

An interim care plan dated 6/2/15, the date of

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resident #2's readmission to the facility after hospitalization at a mental health hospital for treatment of physical aggression directed toward other residents included the following;

o 3 day charting due to readmission

o Monitor Vital Signs every shift

o Behaviors and medication compliance

o Physician to be notified of any adverse or physical aggressive behavior due to history. If physical aggression occurs, placed resident on 1:1 immediately, notify psychiatrist, notify law enforcement.

The care plan developed upon resident #2's readmission lacked measurable goals and individualized, specific interventions related to increased monitoring/supervision of the resident due to the recent history of aggression, and interventions to prevent additional aggression before it occurred. The revised care plan included only interventions to address aggression once it occurred and lacked preventative interventions including the need for increased supervision to protect other residents.

The clinical record lacked evidence of additional supervision of resident #2 upon his/her return from the mental health hospital on 6/2/15 as related to the recent history of aggression/violence against other residents and hospitalization for treatment of those outbursts. The facility provided a document which listed all facility residents and on which staff initialed the box under each resident's nameevery two hours. According to Administrative Staff B, staff who

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initialed the boxes were required to actually see the residents when they placed their initials on that form. Although requested, the facility could not provide any documentation that staff monitored/supervised resident #2 more closely after his/her readmission to the facility on 6/2/15.

During observations on 6/9/15 at 2:25 p.m. and 6/10/15 at 8:00 a.m., resident #2 continuously paced the hallways. The resident did not initiate conversation with others during the observations and did not exhibit signs of aggression/violence.

During an interview on 6/9/15 at 4:10 p.m., Administrative Nurse C reported a mental health screener determined resident #2 required admission to a mental health hospital in early May 2015 after he/she had two physical altercations with other residents within a short time period. According to Nurse C, resident #2 returned to the facility from the mental health hospital on 6/2/15.

The facility's "Abuse Prevention Program" policy with a revision date of September 2012 included, "The facility administration and employees are committed to protecting resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individuals."

The facility failed to provide resident #2 with adequate supervision to prevent accidents/hazards.. Resident #2 had two incidents of aggression/violence against other residents which necessitated his/her hospitalization at a mental health hospital. Upon

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F 323	Continued From page 49 resident #2's readmission to the facility on 6/2/15, the facility failed to develop and implement appropriate individualized, specific interventions related to recent aggression/violence directed at other residents, including increased supervision in an attempt to protect all residents.	F 323		
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. Based on interview and record review, the facility failed to ensure nurse aide competency when 5 of 9 certified nurse aides/certified medication aides failed to participate in ANE (abuse, neglect, exploitation) training upon hire and/or every 12 months. Findings included; - As requested on 7/14/15 the facility provided a list of all staff members, including certified nurse aides and certified medication aides. The list also included the dates the aides last received ANE training. According to that list, the facility employed 9 nurse aides. Of the 9 aides, 5 lacked evidence of training at the time of hire and/or training within the past 12 months as follows: o Direct Care Staff G: Hired on 4/6/15 and no	F 498		

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evidence of ANE training

o Direct Care Staff H: no evidence of ANE training since 3/8/14

o Direct Care Staff K: no evidence of ANE training since 3/4/14

o Direct Care Staff I: Hired on 6/23/15 and no evidence of ANE training

o Direct Care Staff J: Hired on 7/2/12 and no evidence of ANE training

During a telephone interview on 7/14/15 at 5:15 p.m., Administrative Staff A reported the facility changed ANE training methods within the past year. Prior to the change, staff did "Silver Chair" training on ANE at the time of hire and then annually thereafter. According to Staff A, the facility lacked current ANE training documentation on some staff, and reported, "We think more staff have had the training but we can't find the documentation of it."

The facility's "Abuse Prevention Program" policy with a revision date of September 2012 included, "The facility administration and employees are committed to protecting residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individual....The abuse prevention program provides policies and procedures that govern...mandated staff training/orientation programs that includes abuse prevention, identification and reporting of abuse...."

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F 498	Continued From page 51 The facility failed to ensure nurse aide competency when 5 of 9 certified nurse aides/certified medication aides failed to participate in ANE (abuse, neglect, exploitation) training upon hire and/or every 12 months.	F 498		